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Defining the Components of Street Outreach for HIV Prevention: the Contact and the Encounter

SYNOPSIS

HEALTH DEPARTMENTS AND COMMUNITY-BASED ORGANIZATIONS across the United States are funded by the Centers for Disease Control and Prevention to conduct street outreach to facilitate risk reduction among a variety of hard-to-reach populations who are at risk for human immunodeficiency virus infection and other sexually transmitted diseases. The interaction between the client and outreach worker is the fundamental element of any street outreach activity. However, little has been written about the relationships that develop on the street between workers and clients to promote, support, and sustain behavior change.

This paper describes two types of interactions that occur in street outreach intervention activities: the contact and the encounter. As part of a comprehensive evaluation of street outreach, interactions between workers and clients were described and analyzed during the formative phase of the AIDS Evaluation of Street Outreach Projects. For purposes of the evaluation, a contact was defined as a face-to-face interaction during which materials and/or information are exchanged between an outreach worker and a client (or small group of clients). An encounter was defined as a face-to-face interaction between a worker and client going beyond the contact to include individual assessment, specific service delivery in response to the client's identified need(s), and a planned follow-up. The contact provides a means to initiate interaction with potential clients in the community. It is the encounter that provides more significant opportunity for helping the client initiate and sustain behavior change.

The discussion suggests techniques for enhancing the encounter between outreach workers and clients using the conceptual framework of the social work helping relationship. Five elements of the encounter are defined and developed: screening, engagement, assessment, service delivery, and follow-up. The encounter represents an enhancement of the traditional street outreach interaction and a more systematic approach to promoting the behavioral change goals of the AIDS Evaluation of Street Outreach Projects. Recommendations are suggested for implementing the encounter in street outreach programs serving hard-to-reach populations.

Social and behavioral interventions are frequently cited among the most important primary prevention activities to stop the spread of human immunodeficiency virus (HIV) infection (1-3). These interventions focus on understanding the population's risks associated with HIV, social contexts which may facilitate or inhibit risk-taking, accessing those most at risk, and supporting individual risk-reduction behaviors. Increasingly public health providers are required to meet the basic medical and preventive health care needs of disenfranchised and disadvantaged groups (4).

As a result, a number of governmental and nongovernmental organizations have adopted street outreach as a core program activity to provide services to underserved or hard-to-reach persons (5-6). Street outreach facilitates the provision of critical health information and services outside of the clinic setting. Outreach workers take their interventions to the streets (7), that is, to the natural settings in which populations live, congregate, work, patronize, or otherwise independently access goods and services (8). Street outreach has been found to be an important method of service delivery to encourage and support behavior change (9-10). Many organizations use both professionals and peers to conduct outreach. Indigenous workers—members of the target communities (such as youth) or people who have engaged in the targeted risk behavior (for example, injection drug use or commercial sex work)—are often retained because of their knowledge of and acceptance by clients. In summary, street outreach is a means to (a) reach populations who do not access traditional health care delivery systems, (b) refer hard-to-reach clients to health and social services and, (c) deliver health information, risk-reduction materials, and prevention services at the point of contact in the community (11).

The interaction between the client and the outreach worker is the fundamental element of any street outreach activity. Yet little has been written about the interactive relationships that develop between street outreach workers and clients to facilitate the processes of behavior change. This paper describes the components of the street-based interaction utilizing the conceptual framework of the helping relationship as developed in the social work literature. This framework assists in defining the duration, content, goals, and methods of street-based interactions for HIV prevention among drug users recruited as part of the AIDS Evaluation of Street Outreach Projects.

Project Background

In 1991 the Centers for Disease Control and Prevention (CDC) funded eight sites in six cities (Atlanta, Chicago, Los Angeles, New York, Philadelphia, and San Francisco) which supported outreach programs serving injection drug users (IDUs) and youth in high-risk situations (YHRS). The Acquired Immunodeficiency Syndrome (AIDS) Evaluation of Street Outreach Projects (AESOP) was developed

by CDC in collaboration with researchers and program managers in each of the sites to better understand client characteristics, enhance street outreach service delivery, and measure the impact of outreach on the risk behaviors of IDUs and youth at high risk for HIV infection (12).

As part of the formative research, each site was asked to describe (a) the activities and services being conducted by outreach projects for members of the target populations, and (b) the interactions between outreach workers and clients. During the first year, each AESOP site conducted a community assessment process (CAP) and behavioral observations to prepare a comprehensive report documenting outreach activities, services, and the outreach worker-client interactions. CAP is a qualitative-based series of individual and group interviews with IDUs, youth, and others involved with the communities (for example, outreach workers, social workers, agency directors, law enforcement personnel, drug-treatment providers, and neighborhood shopkeepers) (12). These formative research data were to be used to increase the effectiveness of service delivery, improve the interactions with clients, and design the outcome evaluation.

Three common types of street outreach services were determined: (a) the distribution of risk-reduction materials and messages, (b) the delivery of HIV prevention services in nontraditional locations or natural settings frequented by the population, and (c) the provision of or referral to other services that supported HIV risk reduction or met immediate social needs (12).

AESOP site staff also were asked to describe contacts and encounters. Contacts were usually recorded as "a brief meeting, interaction, or exchange" variously aimed at "materials distribution, counseling, or referral." The content or methods of the contact were rarely discussed. When AESOP outreach workers first entered a new neighborhood or other setting, many of their initial interactions with client populations were very brief. These interactions often consisted of no more than offering a person a brochure or a condom. Communication was limited in a contact, and workers usually made assumptions about client needs rather than conducting client-centered assessments. However, despite brevity and the appearance of superficiality, these contact interactions served an important function. Outreach workers had to establish a presence and build credibility among client populations. By conducting contacts, street outreach workers gave potential clients exposure to the range of available services.

Encounters tended to be described as "intensive or lengthier interactions." The goals of the encounter could not be clearly distinguished from the contact, although client needs assessments were identified by some programs as an important element of this interaction. Some AESOP street outreach workers, working regularly in intervention neighborhoods, reported that more of their interactions with clients lasted longer and increased in substance. Some workers and clients came to know each other by name. Brief contacts developed into more substantial encounters.

Although the AESOP programs stressed the importance of the nature and quality of street interactions between the clients and the outreach workers in delivering these services, there was no clear consensus on how to differentiate the duration, goals, content, and methods of these interactions.

Building on this formative research and observations of street outreach contacts and encounters, operational definitions of the contact and encounter concepts were developed. Contacts were defined as face-to-face interactions involving screening and engagement for the purpose of providing materials and/or information to a client (or small group of clients). The AESOP encounters were defined as face-to-face interactions that go beyond the contact to include client-centered assessment, service delivery in response to the client's identified need(s), and a planned follow-up. Although every contact did not always lead to an encounter, every encounter did begin with a contact.

The AESOP Encounter

Using the framework of the social work helping relationship (13), five elements of the AESOP encounter were identified: screening, engagement, assessment, service delivery, and follow-up. This modified helping relationship represents an enhancement of the traditional street outreach interaction and a more systematic approach to promoting the behavior change goals of AESOP.

The focus of the remaining discussion will be on the application of the encounter in interactions with drug users. Specific intervention goals of the AESOP street outreach encounter with drug users are to (a) increase HIV/AIDS knowledge, (b) increase condom use, (c) increase bleach use, and (d) reduce needle-sharing behaviors. Similar to the helping relationship, street outreach workers intervene with clients guided by the clients' individual needs and readiness to change. Workers enter into their clients' own environments to create opportunities to deliver services and facilitate adoption of HIV risk-reduction behavior.

Screening

When a person was met on the street, an outreach worker formed an opinion about the appropriateness of an intervention contact. AESOP outreach workers did not approach everyone they met on the street; some workers relied on sensory cues or other nonverbal communications to decide whether or not to approach a person. Workers stated that a potential client simply "looked approachable." Others reported that clients initiated the interactions. If a client maintained eye contact with an outreach worker, he or

she was described as "inviting" a contact. Conversely, the individual who deliberately looked away from the worker was believed to be saying, "Don't bother me." Often this phase reflected the outreach worker's informed opinion or educated guess about the client's situation rather than the client's own perception of his or her needs.

This initial activity provided a critical foundation for a later, more client-informed assessment. Screening served as a kind of instantaneous intake assessment during street outreach interactions.

Engagement

During engagement the worker established rapport with the client and endeavored to reduce threat and gain trust by demonstrating genuine interest and concern. The results of an initial engagement effort usually determined whether or not a contact progressed to an encounter. AESOP outreach workers established and maintained the interest of clients through both directive and nondirective verbal communications. Workers often opened engagements by explaining their presence, for example, "We're in the community passing out information about AIDS." Conversations usually moved from discussing very general issues, like the weather or last night's big sporting event, to specific HIV/AIDS issues. Outreach workers used this time to demonstrate positive regard for clients and interest in their well-being (14).

The establishment of rapport and exploration of needs were accomplished over time. Once rapport began to develop, the worker could pursue a more client-centered assessment of needs and risks (14, 15). Although every successful engagement did not lead to immediate service delivery, these engagements contributed to the general construction of credible relationships between the outreach program staff and their targeted communities.

Assessment

With engagement, outreach workers initiated basic assessments of clients' needs to help determine appropriate service delivery. During assessment, it was critical to examine client needs from the perspective of the client and give the client the opportunity to determine his or her behavioral goals. Outreach workers also explored their clients' expectations of the intervention event or service. This participatory process improved the client's commitment to practicing the desired behavior (15).

Working closely with the client, workers incorporated the client's ideas and opinions regarding the resolution of his or her needs. For example, AESOP outreach workers found that some drug users were not interested in entering drug treatment, but that they were very committed to

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reducing their risk for HIV, so workers would supply bleach kits and, as appropriate, demonstrate their proper use.

During the assessment phase, AESOP outreach workers employed strategies to increase the client's sense of self-efficacy by identifying the client's strengths and skills. Using open-ended questions, AESOP workers probed for successes in clients' daily experiences. While these successes were not always specifically related to HIV/AIDS or health outcomes, they nevertheless represented important client strengths. The workers could translate these identified strengths to health-promoting practices. For example, a woman who reported that she negotiated with her boyfriend to buy her baby's diapers might also be successful in negotiating condom use with this same man. AESOP outreach workers learned to stress the positives of any kind of survival skill. Crucial to the success of intervention efforts is starting where the client is in the process of behavior change and maximizing his or her strengths.

Service Delivery

In the AESOP encounter, service delivery is the provision of either direct or indirect services to the client congruent with the client's identified needs. Although services also are provided during the contact, needs tend to be presumed rather than assessed. The primary objective of "action-oriented" or "change-oriented" (16) service delivery during the encounter is to enable and/or empower the client to take action toward health-promoting behaviors by supporting client self-awareness, confidence, and problem-solving skills.

In AESOP, HIV prevention-oriented direct services ranged from the provision of basic AIDS information to escorting clients to sexually transmitted disease (STD) clinics. Sometimes outreach workers provided referral cards for appointments and bus tokens for transportation to service agencies. Some workers found they needed to give simple information such as agency office hours or addresses. Other times they actively advocated for clients, circumventing usual waiting lists for services for those in crisis. AESOP workers discovered that effective service delivery was best achieved when needs assessments and interventions were client-centered and workers were cognizant of clients' physical and social environment (17, 18).

Time constraints notwithstanding, street outreach workers practiced techniques of the empathic response and reality confrontation (19). AESOP outreach workers often emphasized their clients' accountability and responsibility for their own behaviors. At times they tactfully challenged clients, firmly addressing clients' dysfunctional behaviors and perceptions that acted as obstacles to goal attainment. During a field visit, one worker was observed saying to an IDU client who had agreed to begin drug treatment, "Man, you didn't do what you said you were going to do. I was looking for you." The client grinned and tried to shrug it off by offering a number of excuses as to why he did not follow through on

the referral, but the worker firmly held him accountable. At the conclusion of this follow-up encounter, the client expressed appreciation for the worker's concern.

Follow-up

The follow-up phase of the encounter has four facets: assessing goal attainment, planning for maintenance of change, successfully terminating the relationship, and evaluating the results of a given intervention (16).

Generally a planned, goal-directed follow-up is not considered to be characteristic of street outreach. As a service delivery method, outreach is usually thought of as a one-shot kind of activity. Yet the opportunity for repeat intervention "doses" does exist in street outreach. AESOP's formative research revealed that the target populations had established congregation patterns and social networks (20). IDUs had favorite corners, preferred shooting galleries, and regular hangouts. AESOP outreach workers often saw the same clients from day to day in their intervention neighborhoods and sites, and were thus afforded numerous opportunities for follow-up.

AESOP workers recognized that some clients experienced inconsistency in their attempts to change behavior. Rather than waiting to run into someone again, workers were able to plan for and provide appropriate support that assisted clients in retrying their risk-reduction efforts (21). In the follow-up phase of the street outreach encounter, AESOP outreach workers reviewed clients' progress toward accomplishing and maintaining a variety of behaviors. Asking basic questions such as, "How did those condoms work out?" or "Were you able to make your appointment?" demonstrated worker commitment to follow-up. Some clients reported successful outcomes. Some kept their STD appointments, entered drug treatment, and used their condoms and requested more. Others reported reductions in needle sharing or requested additional bleach kits. Clients regarded the workers' attention to follow-up as an indication that the workers were truly interested in their health and well-being.

Recommendations for Enhancement

The helping relationship provides a conceptual framework for the enhancement of interactions between street outreach workers and members of target populations. Although there is an implied order to the street outreach encounter, the identified elements—screening, engagement, assessment, service delivery, and follow-up—may vary in sequence. This often holds true in the social work helping relationship. Service delivery can facilitate engagement, or an ongoing assessment will occur during follow-up encounters. Both the encounter and the helping relationship require flexibility in application. The primary requirement of either is that they be client-centered.

To enhance the screening element of the encounter, out-

reach programs, in conjunction with their workers, can develop explicit criteria for approaching clients in street outreach settings. Some AESOP outreach workers reported that they had a feeling they should approach or avoid a prospective client. While instinct can play an important role in the delivery of street outreach, particularly as relates to field safety, programs cannot afford to rely solely on their workers' intuition about a prospective client. Given that many of the risk behaviors associated with HIV transmission are not always readily apparent, assuming that one can just tell who should be approached may result in denial of needed services. Because the mission of street outreach is to make programs more accessible to hard-to-reach populations, it is important that outreach workers do not screen out clients who do not invite intervention.

To facilitate engagement, it is recommended that street outreach programs incorporate training in communications skills. Even workers who can "walk the walk and talk the talk" may need assistance developing a nonjudgmental attitude that demonstrates acceptance of clients, respects their rights to self-determination, and appreciates their problem-solving capacities.

The importance of engagement is best exemplified as part of the assessment process. As an element of the encounter, assessment of individual client needs can also shed light on the needs of an entire community or target population. Street outreach workers must understand that assessment is a comprehensive, ongoing process. In a single encounter, clients are not likely to express all their needs. A theoretical approach to needs and risk assessment that elicits the client's perspective, considers the physical and social environments, and allows for change over time can contribute significantly to the quality of information obtained (22, 23). Theoretically based approaches to assessing client needs and risks and delivery of targeted risk-reduction messages are currently being implemented and evaluated through CDC-funded collaborative projects (for example, the AIDS Community Demonstration Projects, Women and Infants Demonstration Projects, and Project Respect). To be more responsive to specific client needs, training is crucial for outreach workers in key theoretical constructs and their application in street outreach settings. For example, one AESOP project has developed a board game based on concepts from the Transtheoretical Model as an instructional tool for outreach workers to improve their assessment and service delivery skills (24).

In a number of cases, conducting the assessment itself may be an important service for the client. Improving assessment during the encounter should better enable the street outreach worker to provide specific behavior change-

oriented services. These services may be as simple as supplying condoms or as extensive as escorting a client to a medical or drug treatment facility. In some cases, the services may not appear to be health-related at all, as in the case of a client needing assistance with understanding a social security award letter. Although street outreach workers cannot be expected to be providers of all services, street outreach

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training curricula and in-service training should give workers information on referral resources. Such training enhances capacity to respond to a range of health and social service needs that are client centered.

Particularly with respect to referrals, follow-up is crucial. Word on the street can travel

quickly, and outreach workers can lose credibility by making referrals to agencies that are inaccessible or hostile to clients. However, the importance of follow-up is not limited to referral services. Behavior change is a process. Monitoring progress is an important function of the encounter follow-up. Workers should assist clients in evaluating intervention events. "Did you use the bleach?" "Were you able to get in the shelter?" "What did your man say about the condoms?" The street outreach workers' role is to guide and support clients' efforts to initiate and sustain behavior change.

Conclusion

Because of its client-centered focus, the enhanced street outreach encounter can be particularly useful for HIV/AIDS risk-reduction activities. Drug users have a high level of risk for HIV in terms of both sexual and drug risk behaviors (25). About half (41-59 percent) in the baseline AESOP sample of IDUs acknowledged they had at least some chance of becoming infected with the AIDS virus (26). Readiness to adopt and maintain safer behavior varied with the type of sex or drug behavior(s) and the type of sex partner (26).

In the social environment endemic to many of the communities where street outreach is conducted, basic survival needs compete for the attention of persons at risk for HIV infection. Add to this the limited perception of personal risk for HIV infection, and some people may in effect remain oblivious to and undisturbed by AIDS information presented through health promotion campaigns (27).

As a public health strategy, street outreach is an important means of reducing and overcoming institutional barriers to health care for disadvantaged groups. This process avoids bureaucratic appointment systems, long waiting lists, and client transportation costs to and from services. By taking health messages and materials to the street, drug users and other targeted populations are made more conscious of

specific health issues. Street outreach workers can respond to clients' questions and address their concerns in nontraditional settings.

The street outreach encounter brings a modified social work helping relationship to underserved, disenfranchised clients who might not otherwise have access to critical public health services. During the street outreach encounter, the outreach worker becomes a partner in client-centered, client-directed interactions. Service delivery is guided by the client's self-identified needs. The enhanced street outreach encounter provides an opportunity to increase the client's perception of risk, improve the client's sense of efficacy, provide direct and indirect services, and enable the client to implement and sustain risk-reducing behaviors to achieve public health outcomes. Currently AESOP is evaluating the effectiveness of the street outreach encounter in achieving these objectives.

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